MDR Tracking Number: M5-04-1366-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on January 16, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises, therapeutic activities, electrical stimulation, mechanical traction, unlisted therapeutic procedures, office visits, CMT spinal, neuromuscular re-education, manual therapy, unlisted special services and ultrasound were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above was not found to be medically necessary, reimbursement for dates of service from 07-16-03 to 10-21-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 16th day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

March 12, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: MDR #: M5-04-1366-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

REVIEWER'S REPORT

Information Provided for Review:
Correspondence and Plan documentation
H&P and office notes
Physical Therapy notes
Functional Capacity Evaluation

Clinical History:
This claimant suffered a work-related injury on ___, to her neck, left shoulder, and low back. She has undergone a considerable amount of chiropractic care and rehab. She has received an EMG, which was normal. She has also undergone 3 MRIs; 1 of the cervical spine, which showed multilevel disc bulges, a thoracic spine MRI, which was normal, and a left shoulder MRI, which revealed a type 3 acromion.

Disputed Services:
Therapeutic exercises, therapeutic activities, electrical stimulation, mechanical traction, unlisted therapeutic procedures, office visits, CMT spinal, neuromuscular re-education, manual therapy, unlisted special services, and ultrasound, during the period of 07/16/03 through 10/21/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment, procedures and services in dispute as stated above were not medically necessary in this case.

Rationale:
The records from July 16, 2003 through October 21, 2003 do not show any documented benefit or improvement to the patient's condition. She appears to be unresponsive, and more aggressive interventions would be warranted, i.e. surgery on her left shoulder, at this point.

According to Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, injuries which are superimposed by a preexisting condition, such as in this case with the left shoulder degeneration, take 1 1/2 to 2 times longer than normal; however, unresponsive cases that continue to fail should be deemed inappropriate for chiropractic care or have reached maximum therapeutic benefit (chapter 8, page 124, section A and section B). The reviewer believes this to be the case with this claimant; therefore, further chiropractic treatment following July 16, 2003 is not deemed medically necessary or reasonable in my opinion.

Sincerely,